OPERA IN PRACTICE: SILENCED MINDS – THE SYSTEMIC NEGLECT OF MENTAL HEALTH IN KENYA

This brief case study examines the use of OPERA, CESR's monitoring framework, to undertake an audit of the state of mental health services in Kenya which was published by the Kenya National Commission on Human Rights in 2011. It is part of a series of case studies produced by CESR to share insights and learning from the use of OPERA in a variety of contexts and settings.

ECONOMIC AND SOCIAL RIGHTS MONITORING

This report on the state of mental health services in Kenya was published by the Kenya National Commission on Human Rights (KNCHR) in November 2011, in response to a CNN documentary that uncovered Kenya's decaying mental health infrastructure. It was based on an "audit" of information gathered from key stakeholders in the mental health sector, including the Ministry of Medical Services; hospital staff and administrators; psychiatrists in practice and academia; and non-governmental organizations providing services to people with mental health disorders. The audit team conducted key informant interviews, held two stakeholder consultations, reviewed secondary literature, and visited a number of mental health facilities around the country in order to provide case studies of the type of care available in Kenya. A researcher from Center for Economic and Social Rights joined the audit team, providing guidance on human rights principles that helped inform the content and structure of the report. Using the four steps of OPERA to frame the report helped KNCHR provide a systematic evaluation of the issues uncovered in the documentary.

Assessing outcomes

KNCHR took up mental health as a human rights issue because the lack of realization of the right to mental health impedes the achievement of other health and development outcomes. Furthermore, people experiencing mental health problems suffer a widespread cultural stigma and worse outcomes in terms of education, vulnerability to violence, and poverty.

What were we trying to measure? To get a clear picture of the state of mental health among the Kenyan population the audit team focused on the following norms:

- Minimum core obligations: Are people in Kenya able to enjoy a basic level of mental health? The entire population has the right to enjoy minimum essential levels of the right to mental health, regardless of the country's level of economic development.
- Non-discrimination: Are there disparities in the level of realization of the right to mental health among different groups in society? All people must be able to enjoy the right to mental health without legal discrimination (de jure) or discrimination in practice (de facto).

How did we measure? To evaluate mental health outcomes, the audit team analyzed indicators reflecting the overall levels of realization of mental health rights in the country and whether there were significant differences between groups of people.

They identified public health indicators from the World Health Organization (WHO) that could show to what degree the Kenyan population enjoyed their right to the highest attainable standard of mental health. These included:

- prevalence of mental health disorders overall;
- prevalence of mental health disorders among particular groups;
- percent of disability-adjusted life years attributed to mental health disorders;

- rates of alcohol and substance abuse; and
- detection rates for mental health disorders.

There was a significant lack of relevant data available specifically for Kenya. Nonetheless, the audit team was able to source some data on each indicator, often by relying on global estimates and calculating what these equated to in Kenya. Available data on these indicators came primarily from government ministries and academic research. Given that much of this data was dated, practicing and academic psychiatrists, civil society organizations, and government officials were also questioned on the scope and scale of mental health disorders in the country.

This data was then measured against relevant human rights standards and national goals to determine overall levels of realization in the country. Where available, disaggregated data was examined to determine if certain groups were being discriminated against.

What did we find? The analysis revealed that Kenya faced significant issues with respect to mental health disorders, which suggested that access to mental health care was marked by disparities.

The data showed that mental health conditions contribute significantly to the health burden in Kenya. Although, there was no up-to-date data about the prevalence of mental disorders in Kenya, global estimates that were supported by consultations with psychiatrists indicated that approximately 10% of the general adult population and 20% of patients seeking primary care presented symptoms of mental health disorder at any one time.

Despite the prevalence of mental health disorders, rates of detection were very low. A study estimated that while only 4.1% of patients in Kenya had been diagnosed with a mental health condition the researchers' diagnoses showed a prevalence rate of 42.3% for symptoms of depression. According to WHO estimates, 75 – 85% of individuals in need of mental health treatment fail to receive any in lower-middle income countries such as Kenya. From this, we estimated that approximately 8.5 million people in Kenya were not receiving the care they need.

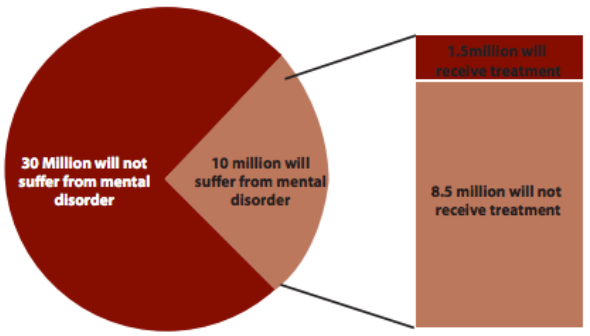

Figure 3: Estimated Treatment Gap in Kenya

Source: own calculation based on WHO global estimates

Further, indicators disaggregated by age-group and socioeconomic factors and discussions with stakeholders revealed higher rates of mental disorders among particular groups, such as those with serious or chronic physical health issues, those who experienced some form of trauma in their lives, prisoners, and individuals living in poverty.

Assessing policy efforts

Kenya has ratified a number of international instruments and passed national legislation that recognizes and obligates the government to realize the right health. This step focused on evaluating such commitments, in particular how they had translated into goods and services on the ground.

What were we trying to measure? This step focused on the following human rights norms:

- Obligation to take steps: Has the government taken sufficient steps to realize the right to mental health? Satisfying this obligation means that Kenya must take concrete and deliberate measures intended to realize the right to mental health.
- AAAAQ criteria: Have the steps taken created the necessary goods and services that meet the standards of availability, accessibility, acceptability, and of adequate quality? In order for individuals to realize the right to mental health, Kenya is obligated to provide necessary goods and services that are available within reasonable distances, accessible to all people regardless of economic or social status, are culturally acceptable and meet adequate standards of quality.
- Participation, transparency, accountability, and right to a remedy: Have people been able to actively participate in the creation and implementation of relevant policies? Rights holders must be able to participate in the creation and implementation of laws and policy. If policies have adverse effects on individuals, there must be mechanism(s) that allow for complaints to be heard and remedies sought.

How did we measure? In order to assess Kenya's policy commitments, the audit team examined the international human rights treaties to which Kenya was a party, as well as domestic laws, policies and programs that included obligations regarding the right to mental health, comparing their provisions to international standards.

To measure the degree to which mental health goods and services meet the AAAAQ criteria, they identified indicators that provide information on what kinds of mental health services were available, where they were available, who had access to them, and the quality of the services. These included:

- The number of facilities available at the district level, including what services the facilities offered such as in-patient, out-patient or rehabilitation services.

- The availability of necessary goods, such as psychotropic medications and qualified health professionals.
- The cost of goods and explicit restrictions placed on accessing the goods (e.g. age limits, gender requirements or limitations on access for criminal offenders).
- The types of services that people preferred to use.
- The conditions of mental health facilities, such as average bed occupancy, quality of physical infrastructure, sanitation conditions, and amenities.

Site visits and consultations with patients, staff, and other stakeholders provided qualitative information related to these indicators. This was supplemented with quantitative data from WHO reports on availability of treatment; a baseline study on treatment practices by BasicNeeds (an international NGO); data from hospital administrators and other health officials; and academic research.

Secondary literature obtained through the stakeholder forums supplemented the above data sources and contributed, in particular, towards analysis of the principles of participation, transparency, accountability, and the right to a remedy.

What did we find? Despite Kenya's ratification of international human rights treaties which include the right to mental health, and important provisions in the Constitution, the country lacked any clear and concrete legislation or programming to realize this right. Further, necessary goods and services did not meet the AAAAQ criteria and there was a significant lack of participation in the creation of policies, especially by people with mental health issues themselves.

With regard to national legislation, the Mental Health Act of 1989 had not been amended since 1991 and did not meet international guidelines such as the United Nations Principles for the Protection of Persons with Mental Illness. Although mental health services could be addressed by the policies, plans, and programs that govern the health sector generally, there was no specific policy for mental health care. The draft Mental Health Policy had not been finalized, seven years after it was first drawn up.

The lack of a specific policy meant that mental health services were delivered in an ad-hoc manner. While the availability of mental health goods and services in the country overall was higher than regional averages, services were highly concentrated in Nairobi—site of the country's only dedicated psychiatric hospital and nearly 70% of in-patient beds. Sub-district and district hospitals were unable to provide appropriate out-patient care at the community-level, which severely limited the availability of treatment for those in rural settings. In addition to distance, the cost of mental health services was another barrier for many.

The research also revealed a number of issues relating to the acceptability and quality of mental health care. For instance, stakeholders reported that mental health staff failed to receive adequate education and training for their positions. Hospital officials indicated that they were not able to provide quality care because of isolated and dilapidated facilities, poor sanitation, and a lack of equipment (including beds). Overcrowding was a common problem in the facilities visited, with one having a bed occupancy rate of over 200 percent.

Participants in the stakeholder forums revealed there were limited opportunities for broad stakeholder engagement in the mental health sector. They also noted a lack of action by the Kenya Board of Mental Health in acknowledging and acting on complaints.

Assessing resources

Many of the problems associated with the delivery of mental healthcare services in Kenya stemmed from underfunding. Thus, in order to provide a complete assessment of the fulfillment of the right to mental health in Kenya it was important to understand whether Kenya was using the 'maximum available resources' to progressively realize the right to mental health.

What were we trying to measure? The audit analyzed how resources devoted to mental health were allocated and spent and the processes used to decide budgets, in order to determine whether they amounted to an equitable and effective use of available resources. The audit team considered:

- Planned and actual resource expenditure: How reasonable was funding for programs concerning the right to mental health?
- Relevant policy processes: Was the public allowed to voice their concerns and desires regarding revenue expenditure and generation? Public voices should be taken into account when budgetary decisions are made, and the process should be transparent.

How did we measure? To evaluate Kenya's obligation to use the maximum available resources, the audit team evaluated the government budget allocated to mental health and the way civil society and the public was allowed to participate in budgetary and fiscal policies.

They calculated how much Kenya allocated to support mental health, as a percentage of its budget, using data from budget estimates 2006/2007-2010/2011 (indexed to inflation). This data was then compared with regional estimates and international standards from WHO data.

They also considered fiscal and budgetary processes and whether they were fair and equitable. They utilized the stakeholder forum and interviews to gain insight into the government ministries and development partners.

What did we find? The analysis showed that Kenya had not allocated sufficient funds to support the right to mental health and there were issues in how the money was spent. As a percentage of the total public health budget, mental health amounted to a meager 0.1%. By contrast, the regional average was 0.6%. When indexed to inflation,

spending had actually decreased between 2006/7 and 2010/11.

Stakeholders also expressed concerns about how effectively allocated resources were being used. When money was spent it did not translate into tangible improvements in mental health outcomes. In the country's only psychiatric hospital, for example, a small number of private units were created to generate income for the rest of the center, but stakeholders failed to see any improvement in care.

Assessment

Contextual factors—be they cultural, political, or social—may limit people's ability to claim their rights or the state's capacity to provide services. Analyzing these contextual factors allows us to bring together information from the previous steps and deliver an overall assessment of a state's commitment to its human rights obligations.

What were we trying to measure? In order to make a thorough judgment of Kenya's compliance with it human rights obligations the audit focused on two contextual factors:

- Constraints facing individuals: What social, political, economic cultural factors limit people's rights enjoyment? Reflecting the indivisibility and interdependence of rights, it is important to identify factors beyond the health sector that might impede an individual's mental health.
- Constraints placed on the government: What other actors or structural factors influence the delivery of mental health care services? Structural factors—such as broader institutional dysfunctions or the conduct of other actors, including other states and international institutions—may limit the government's ability to deliver mental health care services.

How did we measure? Stakeholder consultations and interviews with staff and administrators were the primary sources of information on the local political, social and cultural context. This was supplemented by newspaper articles, investigative journalistic reports and the aforementioned CNN documentary. The audit team also cited a survey on public attitudes towards mental health.

What did we find? Stigma surrounding mental health conditions was widely held and deep rooted, which marginalized mental health patients and made government actors reluctant to take actions to support mental health. According to interviewees, the international community had similarly paid less attention to mental health issues than other issues in Kenya. Research cited in the report indicated that 1 in 20 Kenyans would prefer to take a mental health patient to a witchdoctor or faith healer rather than a mental health facility. Stakeholders reported that patients were often taken to facilities far from the home by their family in order to hide their affliction from the rest of the community. This stigma severely limited the ability of people suffering from mental health and their advocates to effectively pressure the government and society to provide sufficient mental health services.

Outcomes, conclusions and lessons learned

The audit report concluded with a set of recommendations to the government on fulfilling its obligations to respect, protect and fulfill the right to mental health. In relation to resources, for example, KNCHR recommended increasing the budgetary allocation to mental health; providing incentives to students to enter the field and professionals to accept placements in underserved communities; and resourcing to the Kenya Board of Mental Health. In relation to tackling stigma, it suggested the establishment of a public education and awareness program and strongly urged the public and private sectors and the international donor community to support research on mental health.

The major challenge in conducting the audit was the lack of readily accessible, reliable, public data, which meant that much of the analysis was based on broad estimates, limited primary data collection, and opinion gathering. Nevertheless, the lack of adequate data was an important finding in and of itself and the report made concrete recommendations in this regard. The audit report provides an interesting example of how OPERA can be used in a less "quantitative" way, but can still provide value in structuring a diverse range of concerns raised by stakeholders in a coherent way to demonstrate non-compliance with human rights norms.

Following the publication of the report, Kenya's National Assembly introduced a number of mental health bills designed to improve the care and treatment of mental health patients. A comprehensive bill was introduced in 2014 which includes provisions to improve mental health treatment. However, this bill has not been passed, and the people of Kenya still struggle to fulfill their right to mental health.

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